To view printable form click here: Prior Authorization Document for Hearing Aids

471-000-205 Form MC-9HA , "Prior Authorization Document for Hearing Aids" and Completion Instructions

DHHS NEBRASKA

Division of Medicaid and Long-Term Care

Prior Authorization for Hearing Aids

Authorization Number

1. Client Medicaid Number		
Client Name		
2. Hearing Aid Dispenser NPI	Taxonomy	
Business Name		
Street		
City	State	Zip Code +4
Phone Number		

Form MC-9HA is used to authorize hearing aids (471 NAC 8-000). Copy this form for office use. Incomplete forms will be returned.

The hearing aid provider shall complete fields 1 - 5, attach a completed DM-5H to Form MC-9HA and forward to the Medicaid Division for review. (See 471-000-205 for completion instructions).

Attach invoice

3. SERVICES TO BE AUTHORIZED CODE	MODIFIER	DESCRIPTION OF SERVICE	AMOUNT
a.	—		
b.	—		
c.	—		
d.	—		

4. Physician Name (From DM-5H) Physician NPI

5. ICD-9-CM Diagnosis Code

6. Additional Information

Denials may be appealed in writing within 90 days of the denial date by addressing a letter to the Director of Medicaid and Long-Term Care requesting a hearing and stating the basis for appeal.

7. Date Request Received

8. I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care. The Department is not responsible for lost, stolen, or damaged rental items.

NOTE: This authorization is void if the client is ineligible for Nebraska Medicaid or is enrolled in Nebraska Health Connection (NHC), the Medicaid Managed Care Program, at the time the service is provided. It is the responsibility of the provider to verify client Medicaid eligibility.

Medicaid Division

Central Office | Signature of Authorizing Agent | Date

MC-9HA Rev. 2/12 [337006]
(DO NOT USE previous version 2/12)

Form MC-9HA Instructions for Completion

Use: Form MC-9HA is used to prior authorize payment for hearing aids as required by the Nebraska Medicaid Program (471 NAC 8-000). Copy this form for office use. Incomplete forms will be returned.

Prior authorization may also be requested and issued using the standard electronic Health Care Services Review - Request for Review and Response transaction (ASC X 12N 278). For instructions, see 471-000-50 Standard Electronic Transactions.

Completion: Providers shall complete Form MC-9HA as follows:

1. **CLIENT MEDICAID NUMBER:** Enter the client's eleven-digit Nebraska Medicaid identification number.

   CLIENT NAME: Enter the client's full name.

2. **HEARING AID DISPENSER NPI:** Enter the 10 digit National Provider Identifier (NPI) of the hearing aid dispenser.

   TAXONOMY: Enter the 10 digit Taxonomy code of the hearing aid dispenser.

   BUSINESS NAME AND ADDRESS: Enter the hearing aid dispenser's business name, street address, city, state and the complete 9 digit zip code. The authorization will be returned to the business name and address listed.

   PHONE NUMBER: Enter the phone number at which the person requesting authorization may be contacted.

3. **SERVICES TO BE AUTHORIZED:** A maximum of four services can be requested on each prior authorization request. For each item or service requested, enter the information listed below:

   Code: Enter the procedure code. See 471-000-508 for procedure codes used by Nebraska Medicaid.

   Modifier: Enter the procedure code modifier, if applicable.

   Description of Service: Enter the description of the item requested.

   Amount: Enter "IC" for items paid at invoice cost. Enter the dispenser's charge for other items requested with invoice of estimated cost.

4. **PHYSICIAN NAME:** Enter the name of the physician that signed the DM-5H, "Physician's Report on Hearing Loss".

   PHYSICIAN NPI: Enter the 10 digit National Provider Identifier (NPI) of the physician that signed form DM-5H.

5. **ICD-9-CM DIAGNOSIS CODE:** Enter "3899".

6. **ADDITIONAL INFORMATION:** Use this section to provide additional information, if necessary.

Do not complete Fields 7 and 8. These sections will be completed by Medicaid staff.

Distribution: The hearing aid dealer attaches the completed Form DM-5H, "Physician's Report on Hearing Loss" to the completed Form MC-9HA and submits to: Department of Health and Human Services, Division of Medicaid and Long-Term Care, P.O. Box 95026, Lincoln, NE 68509-5026.

If the services are authorized, Medicaid Division staff will sign and date Form MC-9HA and return one copy to the hearing aid dispenser.

If the services are denied, Medicaid Division staff will note the denial on Form MC-9HA and return one copy to the hearing aid dispenser. Denials may be appeal in writing within 90 days of the denial date by addressing a letter to the Director of Medicaid and Long-Term Care requesting a hearing and stating the basis for appeal.